CASE STUDY

ETHIOPIA

With relatively limited health spending (US$ 29 per capita annually), Ethiopia has significantly improved its health outcomes.[1] This is largely due to the government's prioritization of primary health care for the entire population, as a step towards the goal of universal health coverage.[2] However, Ethiopia still faces challenges. While the country saw a 70% decline in maternal mortality between 1990 and 2014, the maternal mortality ratio remains at 353 per 100,000 live births. The under-5 mortality rate is 58.5 per 1,000 live births. A skilled attendant is present at 28% of births. Only 32% of pregnant women receive four antenatal visits.[3] See Table 1 for key demographic and health indicators.

Moreover, this limited health spending currently relies heavily on development partner funds and out-of-pocket expenditure (36% and 33% of total health spending, respectively).[4] An estimated 6% of government spending is on health.[5] Patients incur fees for essential services, specifically for supplies, labs and medications such as antibiotics for common infections. In a household survey, 40% percent of people interviewed stated that the cost of care prevents them from seeking services, contributing to low health care utilization (0.6 visits per capita).[6] Efforts to address the benefits package, and in turn the cost-sharing arrangement between individuals and the government, should produce important improvements in health care access, and ultimately in health outcomes.[7]

Prioritizing the benefits package: Ethiopia's 2005 Essential Health Service Package (EHSP) outlines three tiers of services: (i) exempt services, which are free for the entire population; (ii) an essential or minimum package of services, for which patients share costs with the government by paying user fees; and (iii) services outside of this package (e.g. more expensive tertiary services) for which patients pay. In addition, a fee waiver exempts the indigent population from user fees for any essential or referred services. The rationale for the EHSP was that, while some health issues (e.g. HIV/AIDS) were well understood and funded, no comprehensive health-care package was in place. This package prioritizes most of the interventions recommended by the Guttmacher-Lancet Commission on SRHR (see Table 2). However, its terms are less explicit about the key areas of prevention and promotion: for example, gender-based violence and cervical cancer are not included (although these issues are now expected to be revisited). The package also includes key services at community and primary care levels, as well as some prevention and promotion services provided through health extension workers.

1 National Health Accounts VI. Government of Ethiopia, 2017.

2 Visioning Ethiopia's path towards universal health coverage through primary health care. Government of Ethiopia, 2014.

3 All numbers from WHO Global Health Observatory, most recent year available.

4 National Health Accounts VI, Government of Ethiopia, 2017.

5 WHO global health expenditure database 2016.

6 Ibid.

7 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

The EHSP is intended to provide for core health and health-related services that are promotive, preventive, curative and rehabilitative and can be delivered at community or primary care level. An appointed task force (see 'Participation') began by identifying core health interventions to address the country's major health problems and disease conditions. These were considered to be essential interventions that people could expect to receive near their homes. Because the package was larger than the available budget, prioritization was required. Stakeholders discussed and considered evidence on necessity ("services that when missed will have a disastrous and intolerable outcome, as in the case of exposure to rabies"), cost-effectiveness, affordability and capacity in terms of human resources to deliver the service, and equity. The existing packages of services for Ministry programmes, including existing plans and guidelines, were a strong consideration.[8]

Participation: The Federal Ministry of Health developed the EHSP in 2005 with support from WHO and USAID, through a task force including various departments at federal and regional levels. Regional governments are able to make amendments to this core package and the cost-sharing arrangements once this was defined, according to resource availability. The EHSP was enforced through quality assurance programmes that monitor its implementation and the health sector generally.

Challenges: Regional and district (*woreda*) health offices have full autonomy over their budgets, leading to variation in the funding and delivery of the package. Limited detail is included about fee structures for essential health services, including how fees will be updated and communicated.

Successes: The first EHSP helped health facilities by clearly stating which health interventions and services should be made available to the entire population. It also helped set comprehensive service delivery standards at each level of care, and was used to raise funds from development partners

8 EHSP. Government of Ethiopia, 2015.

to expand primary health coverage, including for system strengthening, as part of a health sector development programme. The Government of Ethiopia played a strong leadership role in advocating with development partners to jointly fund this EHSP. The resulting joint fund was used to pool and allocate development partners' funding for these essential services and system strengthening needs. This was enabled by the framework of the Ethiopia International Health Partnership compact. The success of the pooled fund was due to a robust costed plan for operationalizing the essential service package, as well as a resource mapping exercise to track how funding is used, within the terms of the plan, to identify gaps and to reprogramme resources. Finally, exempt services, often paid for through the pooled fund, are communicated to the public through signage outside facilities that can be easily read by patients, enabling them to hold providers accountable for free care.

Table 1. Ethiopia: key demographic and health indicators

Total population (2016)[1]	102,403,000
GNI per capita (PPP international US$, 2013)[1]	1,350
Life expectancy at birth M/F (years, 2016)[1]	64/67
Total expenditure on health as % of GDP (2014)[1]	4.9
Out-of-pocket expenditure as % of current health expenditure (2016)[2]	37
Voluntary health insurance as % of current health expenditure (2016)[2]	1
Nurses & midwives / 10,000 pop. (2017)[3]	8.4
Physicians / 10,000 pop. (2017)[3]	1.000
Percentage of births attended by skilled health personnel (2011-2016)[4]	27.7
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2014)[5]	59.4
Abortion at the woman's request (Y/N)[6]	

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] African Statistical Yearbook 2018 https://www.un-ilibrary.org/economic-and-social-development/african-statistical-yearbook-2018_197757d1-en-fr
[4] Demographic and Health Survey 2016 https://microdata.worldbank.org/index.php/catalog/2886
[5] 2017 Performance Monitoring and Accountability 2020, Round 5 https://www.pma2020.org/pma2017-ethiopia-round-5-soi-table-en
[6] Global Abortion Policies Database https://abortion-policies.srhr.org/country/ethiopia/

Reforms, revisions and plans for the future: The Government of Ethiopia's new Health Care Financing Strategy aims to address resource constraints and out-of-pocket spending by changing the way in which funds are raised, redistributed and spent through a broader health financing reform. This includes a community-based health insurance scheme at the district level, which has been launched in 374 districts, and a social health insurance scheme that has not yet been launched.

Currently, almost all services available in the public sector are included in the community-based health insurance benefits package, which explicitly includes all services except those specifically excluded (such as eyeglasses and tooth implants). The revised scheme replaced fee waivers were with premium waivers. Having reviewed the initial evidence from these schemes, the Government will consider whether and how to adjust the benefits package to include greater specification of the services included.

In parallel, the Ministry of Health, together with key stakeholders, plans to revise the 2005 EHSP in 2019. This will influence the insurance benefits package (which includes services provided at public facilities). However, it is not yet clear whether it will include a more explicit link to insurance. The revised list is intended to include all cost-effective and high-impact interventions that are already available, as well as listing additional interventions prioritized according to the following criteria: cost-effectiveness, equity, impact and financial risk protection, particularly for the poor, based on the WHO principle of "making fair choices".[9] Additional criteria, such as the severity of the health problem, urgency and public and political concerns, will be taken into account through consultation, public hearing and discussions with stakeholders. This list will also reflect an increased focus on the continuum of care.

SRHR actors can play an important role by generating evidence to show what is needed to deliver this package of services (e.g. systems strengthening). They may find entry points to influence resource allocation and user fee revision at regional and local levels. In addition, there will be opportunities to inform the process of updating this package, and the services covered by insurance over time. For example, as there are changes in resource availability (e.g. development partner transition) and service availability (e.g. the introduction of cancer services).

9 The methodology was based on: Making fair choices. WHO, 2014. https://www.who.int/choice/documents/making_fair_choices/en/

Table 2. Interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from Ethiopia's health benefits package

Interventions recommended by the Guttmacher-Lancet Commission	Ethiopia Essential Health Care Package - interventions included/omitted
Comprehensive sexuality education*	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Health posts: counselling and provision of condoms, mini pills, combined pills and injectables • Health centres: provision of long-term contraceptives, including Norplant, IUD • District hospitals: provision of all forms of family planning, including permanent methods; treatment of abnormal menstruation including D&C • Community-level activities include family planning information and services and activities during pregnancy and breastfeeding
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Health posts: antenatal care and follow-up of pregnant women, provision of supplements, and information/education/communication • Health centres: comprehensive antenatal care, screening and management of pregnancy conditions, management of complications in neonates • District hospitals: skilled intervention for high-risk mothers, including in-patient and maternity waiting area
Safe abortion services and treatment of complications of unsafe abortion	• Health centres: management of abortion, including manual vacuum aspiration • District hospitals: management of complications
Prevention and treatment of HIV and other sexually transmitted infections	• Health posts: information, education, communication and counselling on HIV/AIDS, support and guidance on home-based care, voluntary counselling and testing (VCT) • Health centres: screening for and counselling on STIs/HIV/AIDS; prevention of mother-to-child transmission of HIV (PMTCT); treatment of AIDS and opportunistic infections (OIs) • District hospitals: VCT; diagnosis and antiretroviral treatment; treatment of OIs; PMTCT
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Not included
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Not included
Information, counselling and services for subfertility and infertility	• Not included
Information, counselling and services for sexual health and well-being	• Health posts provide information, education, communication and counselling on sexuality and related issues, including HIV/AIDS and HIV testing and prevention

* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

The Partnership for Maternal, Newborn & Child Health

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